

**Department of
Health & Social
Services**

**Division of Medical
Assistance**



**Health Facilities
Licensing
and Certification**

**4730 Business Park Blvd. Suite 18
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FFY 2000

Application for Initial Designation
& Initial/Renewal of License as a

CRITICAL ACCESS HOSPITAL

The undersigned hereby makes application for designation and license (or renewal of license) to operate a critical access hospital subject to the provisions of AS 18.20.040, and to applicable rules, regulations, and standards adopted under the provisions of the Alaska Administrative Code.

TYPE OF APPLICATION:

☐ INITIAL CRITICAL ACCESS HOSPITAL DESIGNATION AND LICENSE APPLICATION

☐ LICENSE RENEWAL APPLICATION

CURRENT STATUS:

Currently designated as a:

☐ General Acute Care Hospital? ☐ Rural Primary Care Hospital?

☐ Critical Access Hospital? ☐ Rural Health Clinic?

NOTE: At the present time there is no licensure category for Rural Health Clinic.

☐ Facility is NOT-FOR-PROFIT

☐ FACILITY IS PUBLIC OR COMMUNITY OWNED?

☐ NONE OF ABOVE?

1. Identification Information:

Facility Name: _____

Address: _____

City and Zip Code: _____

Phone Number: _____

Administrator: _____

Type of Ownership: _____

Type of Facility: _____

2. Premises located at: _____
(Indicate if different from mailing address.)

3. Legal name of individual or organization operating this facility:

4. If facility is operated on a lease or rental basis, please specify ownership:

5. Future Expansion: Does your facility plan to add new or delete present services and/or facilities during the next period for which this license is issued?

☐ Yes, please specify: _____

Estimated cost: _____

Certificate of Need Application Submitted: _____ / _____ / _____

☐ No

6. Facility has current Malpractice Insurance: ☐ No ☐ Yes (If yes, please fill in below)

COMPANY		
ADDRESS		
EXPIRATION DATE		

7. Application for Licensed Beds:
Total number being applied for: _____
Number of designated beds:
 Inpatient Care _____
 Swing Beds _____

8. Patient Statistics: Facility average daily census:

9. Please check services offered:

Surgical	<input type="checkbox"/>	Laboratory	<input type="checkbox"/>	Dietary	<input type="checkbox"/>
Anesthesia	<input type="checkbox"/>	Emergency Care	<input type="checkbox"/>	Outpatient	<input type="checkbox"/>
Perinatal	<input type="checkbox"/>	Medical Records	<input type="checkbox"/>	Laundry	<input type="checkbox"/>
Medical	<input type="checkbox"/>	Rehabilitation	<input type="checkbox"/>	Resp Therapy	<input type="checkbox"/>
Nursing	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Radiology	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	Psych Therapy	<input type="checkbox"/>
Social Service	<input type="checkbox"/>	Occ. Therapy	<input type="checkbox"/>	Nuclear Medicine	<input type="checkbox"/>

10. On-site Primary care staff: (Please list full-time equivalents)

_____ Physician	_____ Physician's Assistant
_____ Certified Nurse Practitioner _____	Other - Please specify _____

11. Direct care staff: (Please list full-time equivalents)

_____ RN	_____ LPN
_____ Nursing Assistant _____	Respiratory Therapy _____
_____ Physical Therapy _____	Occupational Therapy _____
_____ Speech Therapy _____	

12. What outpatient services does the facility provide?

13. List services provided through contract:

14. List names and credentials for the following department heads as they apply:

Medical Staff: _____	Title: _____	Lic. _____
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Dir. of Nursing:	_____	Title:	_____	Lic.	_____
Social Services:	_____	Title:	_____	Degree	_____
Dietitian:	_____	Title:	_____	Lic.	_____
Food Supervisor:	_____	Title:	_____	Degree	_____
Laboratory:	_____	Title:	_____	Degree	_____
Rehab Services:	_____	Title:	_____	Degree	_____
Anesthesiology:	_____	Title:	_____	Lic.	_____
Infection Control:	_____	Title:	_____	Lic.	_____
Staff Development:	_____	Title:	_____	Degree	_____
Pharmacy:	_____	Title:	_____	Lic.	_____
Quality Assurance:	_____	Title:	_____	Degree	_____
Outpatient Svcs:	_____	Title:	_____	Degree	_____
Preventive Maint:	_____	Title:	_____	Degree	_____
Risk Management:	_____	Title:	_____	Degree	_____

15. What level Emergency Department does the facility currently have, as defined in the Alaska EMS Goals (February 1996)?

- | | | |
|---|--|--|
| <input type="checkbox"/> Level I Isolated | <input type="checkbox"/> Level I Highway | <input type="checkbox"/> Level II Isolated |
| <input type="checkbox"/> Level II Highway | <input type="checkbox"/> Level III | <input type="checkbox"/> Level IV |
| <input type="checkbox"/> Level V | | |

16. Does the facility currently maintain 24 hour staffing in the Emergency Department with a RN, Physician's Assistant, Certified Nurse Practitioner, or Physician?
☐ Yes ☐ No

17.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

 The facility has guidelines for patient teaching.

18.

<input type="checkbox"/>	<input type="checkbox"/>
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 The facility has a preventive maintenance program, which includes calibration for all patient care and laboratory equipment.

19.

<input type="checkbox"/>	<input type="checkbox"/>
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 The facility has a comprehensive infection control program, which includes the reporting, and review of all departments.

20.

<input type="checkbox"/>	<input type="checkbox"/>
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 The facility has guidelines for the transfer of patients to other facilities.

21. ☐ ☐ The facility has quality assurance and risk management programs, which include all hospital departments.
22. ☐ ☐ The facility has a staff development program which services all hospital departments.
23. ☐ ☐ The facility has guidelines for the detoxification process.
24. ☐ ☐ The facility is located in a rural area of no more than 10,000 residents based on calculations of the United States Bureau of Census.
25. Does the facility meet ☐, or intend to meet ☐ the requirements for licensure and Medicare certification as a critical access hospital?
26. If the facility does not now meet requirements as a critical access hospital, please indicate date the facility will be in compliance. ___ Please attach explanation.
27. Please indicate in mileage to nearest hospital _____ AIR ☐ HIGHWAY ☐
28. If by highway, please indicate type of road. Primary ☐ Secondary ☐
29. Does the facility agree to limit the average inpatient length of stay to a 96 hours following critical access hospital certification?
☐ YES ☐ NO
30. If this for an initial designation and license, has the facility conducted a financial feasibility study? (NOTE: this should be an analysis of the financial impact of CAH conversion.)
☐ YES ☐ NO
31. Please attach copy of results of the financial feasibility study.
32. If this for an initial designation and license, has the facility conducted a community needs assessment? (Note: This should be a data driven analysis of availability and utilization of health care services to determine whether CAH is needed.)
☐ YES ☐ NO
33. If this is an application for designation and initial licensure for conversion to a critical access hospital, please attach an explanation of how conversion will promote regionalization of rural health services, and improve access to hospital care and other health services in the community you serve.
34. Please attach documentation of methodology and results of the Community Needs Assessment.
35. Has the facility provided public information and education?
36. Please attach documentation and evidence of the provision of public information and education.

RURAL HEALTH NETWORK

37. Is the facility part of a network partnership? ☐ YES ☐ NO

38. Network full service hospital partner facility name

39. Does your facility have network agreements including:

☐ YES ☐ NO Transfer

☐ YES ☐ NO Referral

☐ YES ☐ NO Communications

☐ YES ☐ NO Non-Emergency Patient Transportation

☐ YES ☐ NO Emergency Patient Transportation

40. Please attach copies of signed agreements

41. Does your facility have agreements with at least one hospital that is a member of the network, or with a PRO or equivalent entity, or with another appropriate and qualified entity identified in the State Rural Health Care Plan, including:

☐ YES ☐ NO Medical Staff Credentialing

☐ YES ☐ NO Quality Assurance

42. Please attach copies of signed agreements

43. Does the facility have referral protocols for members of the network?

☐ YES ☐ NO

44. Please attach copy of EMS plan.

45. Does the facility have a description of the services it will provide directly and those, which will be provided through agreement or arrangement by other providers or organizations. ☐ YES
☐ NO

(Please attach copies of agreements/contracts with other providers and organizations for services provided by the facility.)

46. Does the facility have telemedicine capability? Please describe:

47. Does the facility have out-reach services? Please describe:

48. Please attach a separate listing of room numbers, number of beds in each room and their primary use. Additionally, include rooms that are licensed for beds, which have been changed to something other than inpatient use and can be converted back to inpatient beds within 24 hours.

NOTE: The Administrator should be prepared to present *Health Facility Licensing and Certification* surveyors with a current bed count during the entrance conference of a licensure survey.

Signature of Administrator

Date